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EAP SUPERVISORY REFERRAL FORM

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee's poor work performance when there is reason to believe that the cause may be due to a personal/medical problem. **THIS FORM AND ALL SUPPORTING DOCUMENTATION MUST BE SUBMITTED TO THE EAP IN DUPLICATE. IF DOCUMENTATION DOES NOT EXIST, PLEASE PROVIDE A SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL. DO NOT SUBMIT WITHOUT ONE OR THE OTHER.**

(Please print in ink, or type) REFERRAL DATE_____

EMPLOYEE'S NAME_____ SS#_____
(Please circle: Mr./Mrs./Ms.)

ADDRESS_____HOME PH._____
(City/County, State, Zip Code)

CLASSIFICATION_____ WK. PH. _____

GRADE_____ EOD_____ DOB _____ CELL PH. _____

DEPARTMENT/AGENCY NAME_____

WORK ADDRESS_____
(Zip Code)

WORK HOURS/SHIFT_____ DAYS OFF_____
(Please use ***non*-military** time)

REFERRED BY_ _____ TITLE_____

PHONE_____ FAX_____

AGENCY EAP REPRESENTATIVE _____ PH._____

TITLE _____ FAX_____

_____ Mailing Address _____

AGENCY EAP REPRESENTATIVE'S SIGNATURE _____

_____

REASON FOR REFERRAL

***First,* check off which type of referral this is. *Next,* check off the corresponding areas that are relevant to this referral; *then* attach documentation or synopsis supporting areas checked and overall reason for this referral. This is a:**

I. ☐ **SUBSTANCE ABUSE REFERRAL**
VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE:
_____Failed random drug test _____ Alcohol related conviction
_____Other_____

II. ☐ **MENTAL HEALTH REFERRAL**
ATTENDANCE *(Please place numbers where numbers are requested)*:

_____ Number of days absent past 12 mos.
_____ Pattern (e.g., Mondays, Fridays, after paydays, before and after holidays)
_____ Number of extended lunches past 6 mos.
_____ Number of times late past 6 mos.
_____ Other_____
_____
_____

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JOB PERFORMANCE *(This area must be impacted for referral eligibility, with supporting documentation attached for items checked)*:

_____Lower quality of work
_____Decreased productivity
_____Increased errors
_____Impaired judgment/memory
_____Erratic work patterns
_____Failure to meet schedules
_____Inability to concentrate
_____Other _____
_____
_____
_____

BEHAVIOR DEMONSTRATED WITH RESPECT TO JOB PERFORMANCE:

_____Avoids supervisors/coworkers
_____Less communicative
_____Unusually sensitive to advice/constructive criticism
_____Unusually critical of supervisor/coworkers/employer
_____Loss of interest
_____Frequent mood swings
_____Disregard for safety
_____Other_____
_____
_____
_____
_____

DOMESTIC VIOLENCE: _____

Have the above issues been discussed with employee? (Yes)_____ (No)_____

Has employee been referred to State Medical Director? (Yes)_____ (No)_____

If yes, when? *(Please attach relevant documents)* _____

IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL *CANNOT* BE PROCESSED WITHOUT "YES" INDICATED BELOW AND EMPLOYEE'S SIGNATURE

I understand that my employer is referring me to the State Employee Assistance Program. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein.

_____ YES, *I will* participate in the Employee Assistance Program. My health insurance carrier is:
_____

_____ NO, *I will not* participate in the Employee Assistance program.

_____ _____
Signature Date

Your agency EAP Representative should forward this form and all supporting documentation *IN DUPLICATE* to:

Maryland Department of Budget and Management
Office of the Statewide Equal Employment Opportunity Coordinator
Employee Assistance Program
301 W. Preston Street, Room 607
Baltimore, Maryland 21201

or Fax to: 410-333-5004

If you have questions, please contact the Employee Assistance Program at 410-767-3800.

FAILURE TO LEGIBLY AND FULLY COMPLETE THIS FORM WILL RESULT IN APPOINTMENT DELAY